STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505413	A. BUILDING _____ B. WING _____	C 09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VISTA CARE CENTERS	625 OKANOGAN WENATCHEE, WA 98801

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F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Colonial Vista Care Centers, LLC on 9/25/13. A sample of 6 residents was selected from a census of 62. The sample included 6 current residents. The following complaints were investigated as part of this survey: #2853040 #2874642 Received Yakima RCS OCT 21 2013 The survey was conducted by : [redacted], R.N. The survey team was from: Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597 Residential Care Services Date 10/2/13. F 309 SS=G 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 000	**PRPEPARATION AND / OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OR FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND / OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY LAW.** **F 309 PROVIDE CARE / SERVICES FOR HIGHEST WELL BEING** 1. Resident # 5 was assessed by ARNP on 9/10/13. The ARNP assessment included obstructed Foley catheter, Hematuria, urine retention, urinary tract infection and Tachycardia. The ARNP treatment plan included Metopropol once for rapid heart rate, antibiotic injections, urine analysis, treatment of fever with Tylenol, flushing the catheter every shift, pushing fluids, bowel management and hourly staff monitoring and documentation. The resident's family legal representative wanted treatment at the facility attempted prior to sending the resident to the hospital. On 9/11/13, IV fluids were ordered and family again preferred that treatment be conducted at the facility. Later on this date, resident was transferred to the hospital due to suspicious emesis that was present.	F 309

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/16/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide necessary care and services to prevent a serious infection for 1 of 3 sampled residents (#5). Resident #5 failed to receive timely catheter care in accordance with his physician's orders and developed an obstruction of his catheter and a systemic infection (involving his entire body) requiring hospitalization/care in the intensive care unit. Findings include but were not limited to: Resident #5: Review of the medical record revealed the resident had multiple medical diagnoses including dementia and an improperly functioning bladder (neurogenic bladder). The resident's plan of care noted he required an indwelling urinary catheter. The catheter was to be changed in accordance with the physician's order. The resident was to use a leg bag when up during the day. The resident's care plan goal was to "have catheter care managed appropriately as evidence by: not exhibiting signs of urinary tract infection..." Physician's orders, dated 9/01/13, documented the Foley catheter (urinary catheter) was to be changed monthly and PRN (as needed) if non-functional. Additionally, the Foley catheter	F 309	Resident's # 5's care plan will also be reviewed and updated to reflect all current orders specific to this resident's catheter care. Resident # 5's monthly catheter care flow sheet will also be reviewed and/or updated to reflect all catheter care orders. Catheter care flow sheets will be printed at month end physician recapitulation by medical records and audited for accuracy. 2. All current residents with catheters will be reviewed to assure all catheter care orders were carried over to October catheter care flow sheets and resident care plans. 3. Licensed nursing staff will be in-serviced on proper catheter care, catheter care assessment, catheter care documentation, catheter irrigation, physician and family notification and physician to nurse protocols.. Catheter care flow sheets will be printed at month end physician recapitulation by medical records and audited for accuracy. 4. Medical records staff will conduct monthly audits for 3 months of catheter care flow sheets to verify correct orders are carried over into the next month and to assure that appropriate assessment and documentation of catheter care in being documented in the resident's medical record.	

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F 309	Continued From page 2 was to be irrigated with 60 cubic centimeters (2 fluid ounces) of normal saline (a salt solution compatible with the body fluids) every evening at bedtime to maintain its patency. Review of the August 2013 catheter flow sheet revealed the resident's Foley catheter was changed on 8/03/13. Nightly catheter irrigations were documented 21 of 31 nights with the last documented on 8/30/13. The September 2013 catheter flow sheet failed to document the order for the nightly catheter flush and contained only an order for a PRN catheter flush with 30 cubic centimeters of normal saline. Instead of the physician ordered monthly catheter change, the directive stated, "change Foley catheter PRN blockage/leaking." No catheter change was noted at the monthly interval (approximately 30 days) after the previous 8/03/13 change. No nightly catheter flushes were documented and no PRN flushes were documented prior to 9/10/13 (following a new order to address a problem with the catheter). Additionally, the nurses were to assess the resident's catheter "Q (every) shift for patency, UTI (urinary tract infection), skin irritation." Of the shifts between 9/01/13 and 9/09/13, documentation reflected the resident's catheter was checked for functionality only 14 of the 27 shifts. Staff Member A, a licensed nurse, was interviewed on 9/25/13 at approximately 12:40 p.m. and stated the nightly catheter irrigation order did not show up on the September 2013 catheter flow sheet despite the physician's order. Monthly catheter changes should be approximately every 30 days. Urinary output was	F 309	5. Expected completion date is October 31, 2013. 6. The Director of Nursing, Medical Records Supervisor and Administrator will be responsible for assuring correction.	10/31/13

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F 309	Continued From page 3 recorded in the computer. A computer generated report identified the resident had 175 cubic centimeters (approximately 3/4 cup) of urine out on the 9/09/13 shift 1 between 11:00 p.m. to 7:00 a.m. Thereafter, no output was documented for three shifts 9/09/13 between 7:00 a.m. and 9/10/13 at 7:00 a.m. Fluid intake was noted as 660 cubic centimeters (about 2 1/2 cups) for the day shift. There were no specific intake entries of lunch or dinner on 9/09/13. Despite a decline in the resident's intake documentation and no noted output after the night shift on 9/09/13, there was no nursing entry documenting an assessment for any changes in the resident's condition. The catheter flow sheet only documented the resident's catheter assessment for patency on the night shift on 9/09/13 (prior to day and evening shifts). No assessment was noted for the day or evening shifts on 9/09/13 on the catheter flow sheet and no irrigation was documented. On 9/26/13 at approximately 11: 50 a.m., Staff Member C, a licensed nurse, was interviewed about the resident's condition the night shift of 9/09/13 going into 9/10/13. Staff Member C stated she didn't remember a lot of specifics. She recalled attempting to flush the resident's catheter that night but had trouble flushing when pushing and pulling (with the syringe). Staff Member C didn't attempt to change the catheter at that time; she thought there was urine present in the bag. When asked about the lack of documentation pertaining to the flush problems and condition of the catheter, she stated she possibly didn't chart the flush and probably should	F 309		

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F 309	Continued From page 4	F 309		

have made a nursing entry related to the problem with the catheter. Staff Member C stated it might have been the night they found a clamp on the catheter tubing. She stated she did not think they took any vital signs on the resident that night.

A 9/10/13 nursing entry (day shift), revealed the resident's family had expressed concern that the resident was "uncontrollably shaking." An assessment of the resident identified his Foley bag was empty. The urinary catheter would not flush. The catheter was changed and urinary output equaled 1200 milliliters (approximately 5 cups of urine). The resident was "still shaky and not quite responsive." The nurse practitioner (ARNP) was notified and evaluated the resident.

The 9/10/13 ARNP documentation revealed the resident was "diaphoretic (cool, clammy skin), pale, and clenching onto the side of the bed. Head of penis is also pale. There is some sediment in the Foley (sic) line but no urine. Once the catheter is changed > (greater than) 800 cc (cubic centimeters) of urine...There is hematuria (blood in the urine), foul odor, and sediment. (The resident) has just returned from therapies in the gym and now he is not responding. Family in earlier and concerned about his situation." The resident's pulse was 135 (very elevated). An hour later the resident's blood pressure (Bp) had dropped from 130/65 to 101/40 and his temperature had risen from 98.8 degrees Fahrenheit (F) to 101.9 degrees F and his pulse remained between 135-142. The resident appeared to be sleeping. The ARNP assessment included: Obstructed Foley catheter, Hematuria, Urine Retention, Urinary tract Infection, site not specified, and Tachycardia (rapid heart rate). The ARNP plan included

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F 309	Continued From page 5 Metoprolol once for the rapid heart rate, antibiotic injections, a urinalysis, treatment of the fever with Tylenol, flushing the catheter every shift, pushing fluids, bowel management, and "staff need to make sure and document and continued to monitor hourly. The resident's family legal representative wanted treatment at the facility attempted prior to sending him to the hospital if needed. Although the ARNP documentation noted hourly monitoring, the actual orders identified monitoring for fever, pulses, and blood pressure for the next 24 hours. Review of the 9/10/13 evening shift documentation by Staff Member B, a licensed nurse, noted the resident was very lethargic, difficult to wake until approximately 6:30 p.m. The resident ate 20% of his dinner. Vital signs (without an identified timeframe) recorded the resident's blood pressure was "65/43 (very low).. when lethargic." The catheter was draining pink urine. At 10:00 p.m. vital signs included a blood pressure of 141/98 and other vital signs were within an acceptable range. On 9/25/13 at approximately 1:55 p.m., Staff Member B stated she thought the drop in the resident's blood pressure was related to the Metoprolol. She was unaware of when the first blood pressure at 65/43 was taken. She checked it later and it had improved. Staff Member B later provided a written statement containing more information about the 9/10/13 evening shift. She recalled at dinner time the nursing assistants had informed her the resident was in a deep sleep. Vital signs were taken and	F 309		

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she found his vital signs to be "normal but BP (blood pressure) low normal." Staff Member B recalled she lost the paper with the resident's vital signs at some point during her shift but didn't realize it until the end of the shift charting time so she went and got another set of vital signs that were normal except for a "very low Bp (blood pressure)". A follow-up Bp recheck revealed all vital signs were normal then and the very low value had not been deleted. She recalled she had checked the resident frequently during her shift.

Review of intake and output records for the 9/10/13 evening shift noted 150 cubic centimeters (a little over 1/2 cup) of intake during the evening shift. No physician notification was found reporting the intermittent low blood pressure reading(s), lethargy, and poor oral intake.

Nursing entries on the night shift 9/10/13 going into 9/11/13 noted the resident had vomiting and had low blood pressure readings of 84/58 and 64/44. The family preferred treatment at the facility and intravenous fluids were ordered. Later in the shift a suspicious emesis (vomit) was present and the resident was sent to the hospital. Resident #5 was sent to the intensive care unit.

Review of the [redacted]13 hospital discharge summary revealed Resident #5 was admitted with a kidney infection complicated by an indwelling urinary catheter and septic shock (from the infection). Initially, he "required aggressive fluids and (a type of medication) to maintain adequate blood pressures."

Observations on 9/25/13 at approximately 3:20 p.m. revealed Resident #5 was up in the

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F 309	Continued From page 7 wheelchair in the dining room by himself. He was wearing a leg bag and there was clear amber urine present. The resident reported he had been in the hospital recently but appeared unable to offer any details. The facility failed to provide care in accordance with physician orders, promptly detect a change in the resident's condition, consistently report ongoing symptoms of physical compromise, and facilitate necessary care in a timely manner.	F 309		